# Graceful Home Limited - Rose Lodge Rest Home

## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by HealthShare Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Graceful Home Limited

**Premises audited:** Rose Lodge Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 19 November 2018 End date: 20 November 2018

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 10

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Graceful Home Limited, trading as Rose Lodge Rest Home, provides rest home level care for up to a maximum of fourteen residents.

Short stay /respite can also be provided subject to bed availability. The home is privately owned and operated by a managing director who operates two other aged care facilities in Auckland. A registered nurse (RN) and team leader provide day to day to day management and clinical oversight with input from the managing director who oversees staffing, building, grounds, equipment and procurement.

There have been no significant changes to the service since the previous surveillance audit in 2017.

This re-certification audit was conducted against the Health and Disability Services Standards and the service’s contract with the district health board (DHB). The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, a family member, the managing director, staff and a practice nurse from the local medical centre. The usual general practitioner (GP) was away on the days of audit and unable to be interviewed. The practice nurse, residents and family member interviewed spoke positively about the care provided.

This audit identified four findings requiring improvement. One is related to food services, two findings in the environment and the other finding was about the safe and secure storage of archived consumer records.

## Consumer rights

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

The Health and Disability Commissioner`s Code of Health and Disability Services Consumers` Rights (the Code) is made available to residents and family/whanau on admission. Their privacy, independence and personal safety are protected. Care and support is provided in a manner which recognises the residents' culture, values and beliefs. Residents` who identify as Maori have their needs met in a manner that respects their cultural values and beliefs. Their care is guided by cultural policies. There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are understood by staff and maintained. Service delivery is based on good practice principles.

Communication is open and resident choices are recorded and acted upon. Adequately documented processes are in place for informed consent. Residents and family/whanau are assisted and encouraged to formulate advanced directives. Advocacy information is available for residents and family/whanau. Links with family/whanau and the community are encouraged and supported by the service provider. A complaints register is maintained with complaints resolved promptly and effectively.

An easy to understand complaints management system is in place. Complaint policies and processes comply with Right 10 of the Code. The complaints received since the previous audit have been managed according to policy and the Code through to resolution. Residents, their family members and staff said they fully understood the complaint process and wouldn’t hesitate to raise concerns if required.

Information about the Code, the complaints process and the Nationwide Health and Disability Advocacy Service, is accessible. Information is provided to residents and their families on entry to the service and when requested. Residents and family members confirmed their rights are met, staff are respectful of their needs and communication is appropriate. Consent forms are provided. Residents and family are given relevant information regarding consent processes. Residents and family/whanau are assisted and encouraged to formulate advance directives.

Professional boundaries are understood by staff and maintained. Service delivery is based on good practice principles. Links with family/whanau and the community are encouraged and supported by the service provider.

## Organisational management

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| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

Governance and all aspects of the business operations are directed by the annual business and quality plan. These describe the scope, direction, goals, values and mission statement for the organisation. The managing director and senior management team are monitoring progress against the service goals and all aspects of the services provided.

The quality and risk management system collects and analyses quality data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families.

Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery. Policies are current and reviewed and updated as needed at regular intervals.

The appointment, orientation and management of staff adheres to good employment practices. There is a systematic approach to identifying and delivering ongoing staff training. This supports safe service delivery and includes regular individual performance reviews. Staffing levels and skill mix meet the changing needs of residents.

Residents’ information is accurately recorded, and not accessible to unauthorised people.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The entry to service process is managed by the clinical nurse and was completed in a timely manner. The general practitioner (GP) was involved in the admission process and three-monthly reviews of medication or as required. The CN is responsible for developing care plans. Care plans and interRAI assessments are completed within the required time frames.

Planned activities are appropriate for the residents’ assessed needs and abilities. Residents and family/whanau interviewed expressed satisfaction with the activities provided by the activities coordinator with oversight from the diversional therapist (DT). There are policies and procedures that clearly document the service providers responsibilities in relation to each stage of medicine management. The service uses pre-packed medication system that is paper based. All medication administration competencies are current.

## Safe and appropriate environment

|  |  |  |
| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Some standards applicable to this service partially attained and of low risk. |

The building has a current warrant of fitness. Furniture, and equipment is being maintained and meet the needs of the resident group. Electrical and medical equipment is tested as required.

Waste and body substances are managed effectively. Staff use protective equipment and clothing when required. Household chemicals and equipment are safely stored. Laundry is undertaken onsite by staff who use appropriate processes to maintain hygiene and safety. The effectiveness of laundry and cleaning services is monitored and evaluated through internal audits and resident/family feedback. On the days of audit all internal and external areas were clean.

Staff are trained to respond appropriately to emergency situations. This includes use of emergency equipment, maintaining emergency supplies and attending regular fire drills. Fire evacuation procedures are regularly practised with residents. Staff were observed to respond and attend to call bells in a timely manner. Communal and individual spaces in the home are maintained at a comfortable temperature.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Rose Lodge Rest Home has a philosophy and practice of no restraint. There were no restraints or enablers in use on the days of audit. Staff education in restraint minimisation and managing challenging behaviours is ongoing. The staff interviewed demonstrated knowledge and understanding about this standard and its requirements should restraints or enablers be required. Policies and procedures meet the standard.

## Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

The infection control programme is developed in consultation with the relevant key stakeholders. The environment is managed in a way that minimises the risk of infection to residents, staff and visitors. The infection control coordinator (ICC) is responsible for monitoring infections, surveillance of data, trends and implementing relevant strategies. There was no infection outbreak reported since the last audit.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 42 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 89 | 0 | 3 | 1 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | There are policies and procedures in place that ensure residents’ rights are respected by staff. Interviewed staff demonstrated knowledge of the Code. The Code is included in staff orientation and in the staff training education programmes. On the days of the audit, staff demonstrated knowledge of the Code when interacting with residents. The residents and family/whanau reported that staff respect their rights and are incorporated as part of their everyday practice. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Residents and where appropriate their family/whanau of choice are provided with the information they need to make informed choices and give informed consent. Policies and procedures on consent support the residents’ right to make informed decisions. The CN reported that informed consent is discussed and recorded at the time the resident is admitted to the facility. The policy references Rights 5, 6 and 7 of the Code and the process for determining competency and advanced directives. The residents' files sampled had the required consent forms signed by the resident, or where appropriate, signed by the enduring power of attorney (EPOA).  The files contained copies of any advance care planning and the residents’ wishes for end of life care. Residents interviewed confirmed that they were provided with day to day choices and consent was obtained. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Advocacy services are discussed with residents and their family/whanau on admission to the service. There were appropriate policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates. The advocacy policy details contact information for the Health and Disability Commission and Age Concern advocacy services. Staff training on the right to advocacy / support is provided annually and staff demonstrated understanding of how residents can access advocacy/support persons. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | There are no set visiting hours and relatives are encouraged to visit at any time. Family/whanau reported that there were no restrictions to visiting hours. Residents are supported and encouraged to access community services with visitors or as part of the planned activities programme. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed said they felt comfortable and wouldn’t hesitate to raise a concern if they had one.  The complaints register reviewed recorded two complaints received in the past two years. These had been acknowledged in writing, and investigated immediately by the managing director. Documentation reviewed confirmed that these matters had been resolved to the satisfaction of the complainant and were closed.  The managing director is responsible for complaints management and follow up. All staff interviewed confirmed a good understanding of the complaint process and what actions are required. There have been no complaints to the Health and Disability Commissioner (HDC) nor any requests for advocacy services to provide support for residents’ in this certification period. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Information about the Code and the Nationwide Health and Disability Advocacy Services are displayed in the facility. The CN reported that an advocate visits the service and can be accessed as required.  Residents and family/whanau interviewed were aware of their rights and confirmed that information was provided to them during the admission process. The information pack outlines the services offered. Signed residents’ agreements were sighted and meet the requirements of this standard and district health board requirements. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The privacy and dignity policy explains how staff are to ensure the privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of residents’ related information. The process for accessing personal health information is detailed and the care planning process identifies and records interventions for respecting residents’ individual beliefs and values. Residents are kept safe and are not subjected to, or at risk of, abuse and/or neglect. Rooms are single or shared and maintain physical, visual, auditory and personal privacy. Residents’ personal belongings are maintained in a secure manner. There are documented policies and procedures on abuse and neglect including the required reporting process. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The Maori perspective on health is documented and includes Maori models of Health and barriers to access. Terminal care and death of the Maori resident is included. Cultural needs are included in the care plans (if identified). There is access to cultural advice, resources and documented procedures to ensure recognition of Maori values and beliefs. There were residents who identified as Maori and expressed that their cultural values and beliefs are respected. The organisation maintains contact with local Iwi. Cultural safety training is provided to all staff. The Code is available in Maori and satisfaction surveys include cultural and spiritual beliefs. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Cultural needs are recognised, respected and determined on admission. Policies and procedures are developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance to policy. Residents’ values and beliefs are discussed and incorporated into the care plans. Residents and family/whanau members interviewed confirmed they are encouraged to be involved in the development of resident centred care plans. In interviews conducted staff demonstrated an understanding of cultural safety in relation to care. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Policies sighted evidence processes for providing an environment that is free from discrimination, coercion, harassment, sexual, financial or other exploitation. The staff code of conduct and professional behaviour is included in the employment and orientation process. The code of conduct states that any form of discrimination constitutes serious misconduct.  Observation during the audit days indicated that residents are free of any form of coercion or discrimination. Staff demonstrated awareness of the importance of maintaining professional boundaries and processes they are required to adhere to. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Residents receive services of an appropriate standard. There are systems in place to ensure staff receive a wide range of opportunities which promote good practice within the facility. Staff reported that they were satisfied with the relevance of the education provided and were able to explain how they maintain good practice. Policies and procedures are linked to evidence-based practice. There are regular visits by the GP and allied health providers as required. The CN is available and accessible to care staff for clinical support and advice when required. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family/whanau reported that they are accorded the right to full and frank information or open disclosure. The environment is conducive to effective communication and interpreter services are provided if required. Policies and procedures are in place if the interpreter services are needed to be accessed. Staff education has been provided related to appropriate communication methods. Documentation regarding open disclosure following incidents/accidents was evident. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The quality/business/risk plan which is reviewed annually, outlines the purpose, values, scope, and direction of the organisation. This also contains detailed annual and longer-term goals. The managing director monitors progress against the business plan and is now involving the group management team at six weekly meetings. External advisors such as a quality consultant, and accountant are consulted and/or provide support services to the business.  The managing director has owned and operated Rose Lodge since 2014 and also operates two other aged care facilities which provide specialist dementia care.  The service holds contracts with the Ministry of Health and Auckland DHB, for rest home level care, long term support-Chronic Health Conditions and residential respite services. On the days of audit, ten of the maximum 14 beds were occupied. There was one additional person of a similar age to the other residents living in the main house as a boarder under agreement with the owner. This is a long term arrangement and staff are continuing with their attempts to have this persons needs assessed.  Of the ten residents, six are funded under the Aged Residential Care Contract (ARCC) one person was receiving care under the residential respite agreement, two residents were funded under the Accident Compensation Corporation scheme and one resident is a private payer. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The managing director has extensive experience in the health sector, which includes owning and operating a home-based support service and working in psychogeriatric care services. The director attends at least eight hours of education per annum by attending industry specific and ADHB training courses.  The managing director allocates their role and tasks to the group administrator during planned or unplanned absences.  The team leader for Rose Lodge oversees the day to day operations, including staffing and service delivery to residents. Personnel records and interviews with this person confirmed they have many years’ experience working in age care, qualifications in aged care and in health and safety. The full time RN shares their hours overseeing the clinical care for the residents across two facilities. The group employs three RNs so there is always on RN on call. All of the RNs have current practicing certificates, are interRAI trained and are maintaining their competencies. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Rose Lodge Rest Home has established quality and risk management systems which includes policies and procedures that guide current accepted practice. The policies used are a generic system moderated by an external quality consultant and these cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.  Review of the business, quality and risk management plan revealed that this is updated annually or as required. Service delivery and organisational performance is monitored by internal audits and resident and family feedback. Results of audits and monthly analysis of complaints, incidents and accidents and infections are considered to identify issues or changes required. Review of documents, observations and interviews, confirmed that the managing director and staff respond to matters that require improvement by implementing corrective actions as soon as practicable.  Staff meetings occur monthly and the managing director is now hosting six weekly management meetings for the RNs, administrator and team leaders across the group to review and discuss resident and operational matters and the outcomes from quality and risk activities. Resident meetings are facilitated by the activities staff and occur every three months. Minutes of these confirmed ongoing consultation and inclusion of residents and their families in decision making. All staff interviewed including the health care assistants, the diversional therapist and the cook, report they are kept informed of any changes and where improvements are needed or implemented.  The comprehensive risk management programme includes health and safety policies and procedures and a current hazard register. Health and safety audits occur regularly. The documents reviewed confirmed that any issues identified are documented in a corrective action plan and signed off when resolved. Hazards identified are risk rated, eliminated, minimised or isolated, and documented in the register. The managing director and team leader confirmed that staff understand the importance of identifying any issues as soon as these arise so these can be fixed immediately. Review of meeting minutes confirmed that health and safety, hazards and management of any other risks is discussed at every staff meeting.  The annual resident/family satisfaction survey and results documented from the 2018 surveys indicate that residents are happy with the service provided. Positive testimonials from families whose loved ones have been cared for at Rose Lodge, were sighted on the group website. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Staff document all adverse and near miss events on accident/incident forms. The sample of forms reviewed from 2017-2018 were consistent in clearly describing and detailing the incident and recording who had been notified. There have been very few incidents (for example, seven incidents year to date in 2018 which included four unwitnessed falls with no injuries, two medicine events and a challenging behaviour). The managing director reviews all incidents/accidents and investigates as necessary. Each incident form reviewed contained a management comment or preventative action for closure or follow-up. The managing director and senior staff demonstrated understanding about essential notification reporting requirements, including for pressure injuries. They advise there have been no events requiring notification to the Ministry of Health, or the DHB since the previous audit. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Staff management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required. Copies of practising certificates for the registered health practitioners (for example the pharmacists, GP and podiatrists) are on file. A sample of staff records reviewed, confirmed the organisation’s staffing policies are being consistently implemented and that individual personnel records are being updated as required.  Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. The personnel records reviewed included documentation of completed orientation, competency assessments and a performance review after a three-month period.  Continuing education is planned on an annual basis and occurs each month. The training topics include mandatory education such as fire drills, first aid and medicines competency for those who administer medicines and other training subjects to meet the requirements of the provider’s agreement with the DHB. The long-term health care assistants (HCAs) have achieved qualifications related to care of older people. A few of the staff employed as HCAs or activities coordinators have nursing degrees from other countries. Each of the staff records reviewed confirmed attendance at ongoing training and completion of annual performance appraisals.  The three registered nurses are trained to undertake interRAI assessments and are maintaining their annual competency requirements. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. (24/7) Observations and review of the monthly roster confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All staff have current first aid certificates. The managing director and the staff interviewed stated that staffing levels are adjusted to meet the changing needs of residents. The director is available afterhours and an RN is allocated on call at all times. Staff stated that ready access to advice is available when needed. All the staff interviewed said they had enough time on each shift to complete the work allocated to them. The residents and a family member interviewed expressed satisfaction with the availability of staff. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low | All records sighted are in hard copies. Residents’ records sighted are integrated. Progress notes are completed daily by care staff and weekly by the CN. Appropriate documentation requirements are met. An improvement is required to ensure archived records are stored securely and accessible. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The entry to service is facilitated in a competent, equitable, timely and respectful manner. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies. Records sampled confirmed all entry requirements were conducted within the required time frames. Family/whanau and residents interviewed confirmed that they received sufficient information regarding the services to be provided. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There is a documented process for the management of transfers and discharges. A standard transfer notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents’ records to confirm this. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | Residents receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. All staff responsible for medication administration are competent with current competencies. Medication management training records were sighted. The service uses a pre-packed medication system. Three monthly medication reviews are completed by the GP. Allergies or sensitivities are indicated, and residents’ photos are used as part of the identification method.  The healthcare assistant (HCA) was observed administering medication correctly. There were no controlled drugs on site. Medication is safely stored in locked cupboards and drug trolley. There were no expired medications on site. HCA administer as when necessary medicines after consultation with the CN. Rationale and effectiveness of medicine given is documented in progress notes.  There is a policy for self-administration of medication. There was one resident who was self -administering medicines and was assessed as competent by the GP. The medicines are stored in a safe and secure manner in the resident’s room. Medication audits are conducted and corrective actions are acted upon. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Moderate | Food, fluid and snacks are available 24 hours a day and all residents interviewed commented on the quality and variety of meals. An experienced and qualified cook is employed to oversee and provide food services and be on site Monday to Friday. Other staff with safe food handling qualifications are allocated kitchen duties which involve serving prepared meals at dinner time and cater the weekend meals.  Rose Lodge uses a three weekly, seasonal menu. This has still not been reviewed by a registered dietitian and has been an ongoing finding since 2016. Action to complete this requirement is now required within one month. Nor could the service provide evidence that their food control plan had been registered.  Residents requiring special or modified diets are catered for. On the days of audit there was one resident requiring a diabetic diet. This resident interviewed expressed satisfaction with the variety and choices of food on offer.  The cook demonstrated how easy to chew meals are provided. No one requires pureed meals. Another resident commented that they are provided with an alternative meal when a dish they don’t like is served.  Food is stored safely with use by or dates plated seen on each item. Fridge/freezer and hot meal temperatures are recorded daily.  There have been no reported concerns about food services. On the days of audit, staff were observed to be offering residents hot and cold drinks at regular intervals. A water dispenser is located in the dining room. Each resident is weighed monthly and any weight loss is investigated. Supplements are provided to residents whose weight is causing concern. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The CN reported that all consumers who are declined entry are recorded. When a consumer is declined entry, family/whanau and the consumer are informed of the reason for this and made aware of other options or alternative services available in the community. The consumer is referred back to the referral agency to ensure that the consumer will be admitted to the appropriate service provider. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Initial assessment tools are used to assess the residents’ needs, support requirements and preferences on admission. InterRAI assessments are completed in a timely manner. The assessed needs, outcomes and goals identified through the assessment process are documented to serve as a basis for service delivery. Assessments are conducted in a safe and appropriate setting. Assessment outcomes are communicated to the residents and/or their family/whanau and referrers and relevant service providers. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans sampled were resident focussed, integrated and provide continuity of service delivery. Short term and wound care plans are completed as required. Residents, their family/whanau and relevant key workers are involved in the care planning process. The care plans sampled described the required support to achieve the desired outcomes identified by the ongoing assessment process. Service integration was sighted in the sampled residents’ files. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The documented interventions in short term care plans and residents centred care plans are sufficient to address the residents’ assessed needs and desired goals/outcomes. Interventions are updated when required and interRAI triggered outcomes are addressed. Specialist advice is sought from other service providers and specialist services when required. Referral documents to other services and organisations involved in residents’ support were sighted in the sampled files. Interviewed families, residents and staff reported that they were satisfied with the services provided. Interviewed staff reported that there are adequate resources to meet safe resident care. Adequate medical/clinical resources were sighted and were appropriate to the size of the facility. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | Activities are planned by the diversional therapist (DT). A monthly planner is posted on the activities boards that are accessible to residents. A resident preference/choice of activities form is completed on admission. The activities provided take into consideration residents’ interests and ability. Residents and their family/whanau are consulted in the activity assessment and planning process. There is a wide range of activities offered: including bingo; quiz; music sessions; walking groups; art and craft. There is community involvement with external entertainers invited, church and music groups. Attendance list is completed daily, and documentation was sighted. Evaluation of the individual activity plans are completed six monthly.  Monthly residents’ meetings are conducted, and outcomes are implemented and communicated to family/whanau and residents. Interviewed residents and family members reported satisfaction with the activities programme. Residents were observed participating in a variety of activities on the days of the audit. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents’ centred care plans, interRAI assessments and activity plans are evaluated at least every six months and updated when there are any changes. Family/whanau and staff are consulted in the review process. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed, signed and closed out when the short-term problem has resolved. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are referred to other health and disability service providers when required. Referral documents were sighted in the sampled files. The CN and GP are involved in the referral process in consultation with the resident and/or their family where appropriate. Informed consent, general consent forms and referral documentation was sighted in records sampled. Residents and/or their family are given the choice and advised of their options to access other health and disability services where indicated. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Staff adhere to the documented processes for the safe management of waste and infectious and hazardous substances, as confirmed by onsite observations and interviews. There are no hazardous chemicals on site, the cleaning products in use are for domestic use and safe handling instructions for these are on the labelled containers. The staff interviewed could clearly describe how to protect themselves and others from exposure to body waste. Soiled linen is separated for washing. There is provision and availability of protective clothing and equipment and staff were observed using this. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | Rose Lodge Rest Home premises are leased from a private landlord and Graceful Home Limited is responsible for the repairs and maintenance of internal fixtures and fittings. A current building warrant of fitness was displayed, which expires 29 August 2019. There have been no building modifications since the previous audit.  Inspection of all interior and exterior spaces revealed three areas that require remedial work. Refer findings in 1.4.2.4 and 1.4.2.6. A builder began repair work to these areas on day two of this audit.  Reactive maintenance is carried out by staff or certified tradespeople where required. The managing director reported the long-term maintenance plan has been developed in consultation with the landlord and accountant. Documents confirmed that medical equipment (for example, thermometer, weighing scales and blood pressure equipment) has been checked and calibrated recently by an external company and all plug-in electrical appliances were tested and tagged by an authorised person this year. Staff interviewed confirmed they have ready access to suitable equipment.  There is easy access to plenty of safe and shaded seating areas outside for residents.  Visual inspection confirmed the service vehicle used for transporting residents has a current warrant of fitness and registration. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are sufficient bathrooms and toilets (for example three toilets and two bathrooms) provided for the number of residents inside the house. All but one bathroom (which is enclosed in the outside room) are shared by residents. These are designated for male and female and there is a separate staff toilet. Hot water temperatures in resident areas are recorded monthly. Records reviewed indicated that temperature testing was within the accepted temperature ranges for the provision of care to vulnerable residents. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | There are 10 bedrooms in the main house, two of which are double rooms and there is an outside sole occupancy bedroom with a bathroom and toilet. Both the double rooms were occupied by two people. Their privacy was being maintained by use of curtains and each of the four residents have signed an agreement to share.  The rooms are spacious and can easily accommodate mobility equipment although only one resident was using a mobility aid. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The home has a welcoming open plan lounge and dining room which is the main hub for daily activity and socialising. Other inside and outside areas are available if someone does not want to participate in the programme or residents may choose to stay in their rooms. Furniture is appropriate to the setting and residents’ needs. All residents are independently mobile enabling them to access all areas including the outside via disability accessible ramps. Visitors tend to meet with their family and friends in communal areas or in their rooms for privacy. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Cleaning and laundry services are completed daily by staff. The tasks and areas for cleaning such as rubbish removal, dusting, vacuuming and bathroom cleaning are allocated to individual staff members on a cleaning roster. Staff interviewed demonstrated good knowledge of cleaning and laundry processes such as dirty/clean flow and handling of soiled linen. The washing machine, dryer and cleaning equipment provided is fit for purpose and in good repair. Staff change each resident’s bed linen once a week and those interviewed said there was sufficient time allocated for completing daily/weekly tasks. Only domestic type cleaning and laundry products are in use (for example, those that can be purchased in supermarkets.) There are no hazardous chemicals on site.  The residents interviewed were satisfied with the level of cleanliness of their home and said that their clothes are laundered regularly and returned to them in good condition with in reasonable time frames. Cleaning and laundry processes are monitored through the internal audit programme. All areas of the facility were spotless on audit days. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is an approved fire evacuation scheme for the building and trial fire evacuations are occurring at least six monthly. Records and attendance logs of fire drills occurring in March and October 2018 were sighted. Staff also complete emergency procedure questionnaires at least annually. The results of trial evacuations are recorded and show how long it took to clear the building and any issues that arose. A hard-wired fire suppression system (sprinklers and smoke detectors) are installed and exit signs are clearly displayed.  The civil defence kit inspected contains essential emergency equipment such as lights, radio and batteries and the contents are checked regularly. Sufficient supplies of potable water and food for the needs of 14 people for three to five days is available and checked/replaced monthly. A gas barbeque is stored on site ready for cooking in the event of power outage. There is no generator on site or emergency lighting system, but plenty of portable torches and batteries are in the civil defence kit. The call bell system is functional, and staff were observed to respond to the bell immediately. This is also checked monthly. Residents said staff were always attentive and responsive.  Interview with the managing director and staff confirmed that security checks of all doors and windows occurs each day at dusk. There have been no security incidents since the previous audit. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All areas of the home have sufficient natural light. Each bedroom has opening windows and the communal areas have ready access to outside. The bedrooms are individually heated by panel heaters and hallways and communal areas have heat pumps. There are surplus quilts and blankets for additional warmth in the event of an electrical power outage. The residents interviewed confirmed the temperatures in the home are comfortable all year round and no issues related to temperatures raised by staff. Designated smoking areas for residents are available and contingencies are in place to prevent passive smoke from affecting other residents. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Rose lodge Rest Home provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The CN is the infection control coordinator and has access to external specialist advice from the GP practice and DHB infection control specialists when required. A documented job description is in place.  The infection control programme is approved and reviewed annually. Infection rates are discussed at staff and management meetings. The ICC attends quarterly meetings with other rest homes owned by the same provider where infection control is discussed. Staff are made aware of new infections through daily handovers on each shift and reporting.  There are processes in place to isolate residents with infectious conditions when required. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented since the last audit and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Collation, analysis and reporting of infection are completed and discussed at management meetings every three months with staff from other two facilities owned by the same service provider. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The service has documented policies and procedures in place that reflect current good practice. Staff were observed to be following the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The service provides relevant education on infection control to service providers, support staff, and residents. The ICC attended the infection control training facilitated by the local DHB to keep knowledge of current practice. A record of attendance is maintained and was sighted. The training content meets best practice and guidelines. External contact resources included: GP practice, laboratories and local district health boards. There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance of infections is carried out as specified in the infection control programme. The ICC reviews all reported infections, and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs. All infections are recorded on the infection register, this information is collated monthly, reviewed and analysed by the ICC who will advise staff and management of the outcome.  The GP is notified if there is any resistance to antimicrobial agents and evidence of GP involvement and laboratory reporting was sighted. Surveillance programme is reviewed during the infection control programme review. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Rose Lodge Rest Home has a philosophy and practice of no restraint. There were no restraints in use on the days of audit. The restraint minimisation and safe practice policy clearly defines the difference between restraint and enablers, and forms and processes are available if a restraint is required. An RN is designated as having overall responsibility for the service approach to restraint/enablers. The sample of staff records reviewed showed that training in the prevention of restraint use, managing falls and challenging behaviours occurs at least annually. |

# Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.9.7  Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable. | PA Low | Old records are archived for 10 years. Residents’ records are stored in locked cupboards in the facility and are accessible when needed however the cupboard with archived records in the garage was not locked and not easily accessible due to clutter. | Archived records in the garage were not secure and accessible. | Ensure all residents’ records are stored securely and accessible when needed.  90 days |
| Criterion 1.3.13.1  Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | PA Moderate | Residents are satisfied with the quality and variety of food provided. There have been no issues about food services raised by residents or their relatives nor any concerns about resident weight loss or eating problems. However, no evidence was produced to confirm that menus have been formally reviewed since 2014. The managing director stated the prices being quoted for three homes was prohibitive and is continuing to search for an affordable authorised service provider to complete these. Staff said the menus had been looked at by a person studying nutrition at a local tertiary institute, but this could not be substantiated by written evidence.  Staff said the food control plan had been completed but had not been submitted or registered on audit day. This was required by 01 July 2018. | 1) The menus have still not been reviewed by an authorised authority or person. This has been an ongoing finding since 2016. The risk rating remains at moderate risk but action is now required within one month.  2) The food control plan has not been registered as required by the Food Act (2014) regulations | Provide evidence that the menu/food provided meets the needs of all residents.  Provide evidence that the food control plan has been registered  30 days |
| Criterion 1.4.2.4  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Low | The environment is appropriate and comfortable for the people who live there, Inspection of the ladies toilet and bathroom revealed degraded floor and wall surfaces. | The floors and lower walls and skirting board of the single toilet in the ladies (north end) of the house requires repair and /or resurfacing. There are degraded surfaces in the lower part of the vanity unit in the bathroom. These provide a barrier to cleaning and compromise provision of a safe and hygienic environment. | Ensure all surfaces are intact, so they are easy to clean and can be maintained as hygienic to prevent the spread of disease or infection.  90 days |
| Criterion 1.4.2.6  Consumers are provided with safe and accessible external areas that meet their needs. | PA Low | There are ramps and easy access to outside areas. Inspection revealed the surface of a wooden deck at the front of the house is slippery. | The surface of the small wooden deck in the very front of the home is covered with mould and poses a slip hazard. | Ensure all outside walking surfaces are slip resistant.  90 days |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.